



Enrollment/Change Form

Please print in all capital letters using blue or black ink. Please complete all sections.

Required sections are marked with an *.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

Employer Information: to be completed by Employer

Employer Name* / / Effective Date** / /

Group Number* Subgroup*

Location Code

^Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Employee Information: to be completed by Employee

Change Type*: Add Term Update Member ID:

Last Name* Date of Birth* / /

First Name* MI Gender* Male Female Phone Number () -

Street Address*

City* State* Zip Code* Social Security Number** - -

Employee Email Address:

^Last four digits of Employee's Social Security Number are required.

Family Information: to be completed by Employee. Only eligible dependents may be enrolled.

Dependent 1 Change Type*: Add Term Update Relationship*: Husband Wife Son Daughter Domestic Partner

Last Name* Gender*: Male Female

First Name* MI Social Security Number - - Date of Birth* / /

Dependent 2 Change Type*: Add Term Update Relationship*: Husband Wife Son Daughter Domestic Partner

Last Name* Gender*: Male Female

First Name* MI Social Security Number - - Date of Birth* / /

Dependent 3 Change Type*: Add Term Update Relationship*: Husband Wife Son Daughter Domestic Partner

Last Name* Gender*: Male Female

First Name* MI Social Security Number - - Date of Birth* / /

Dependent 4 Change Type*: Add Term Update Relationship*: Husband Wife Son Daughter Domestic Partner

Last Name* Gender*: Male Female

First Name* MI Social Security Number - - Date of Birth* / /

Employee Signature*: _____

Date*: / /

For additional dependents, please complete a second form.